

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN4711	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/12/2011
NAME OF PROVIDER OR SUPPLIER NORTHAVEN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3300 BROADWAY NE KNOXVILLE, TN 37917		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	<p>1200-8-6 No Deficiencies</p> <p>During annual Licensure survey and complaint survey #28776 and #28568 conducted on October 12, 2011, at Northaven Health Care Center, no deficiencies were cited in relation to the complaint under 1200-8-6, Standards for Nursing Homes.</p>		N 002		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Ruby Dechen

TITLE

Administrator

(X6) DATE

10/28/11

STATE FORM

6899

JR9Y11

If continuation sheet 1 of 1

OCT 28 2011